

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SA000014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/03/2020
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NAME OF PROVIDER OR SUPPLIER HAGERSTOWN REPRODUCTIVE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>A complaint investigation survey of Hagerstown Reproductive Health Services was conducted on March 3, 2020.</p> <p>Complaint number: MD00151331. This complaint was unsubstantiated.</p> <p>The survey included: an on-site visit to the facility; interview of staff; review of patient clinical records; review of staff credentialing files and review of other pertinent documentation.</p> <p>Findings in this report are based on data present in the administrative records at the time of the review. The facility staff was kept informed of the investigational findings as the investigation progressed. The agency was given the opportunity to present information relative to the findings during the course of the investigation.</p> <p>Hagerstown Reproductive Health Services is in compliance with COMAR 10.12.01.00-10.12.01.20 F. for Surgical Abortion Facilities.</p>	A 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE